THIRD AMENDMENT TO THE
MAY 1, 2020
COMBINED SUMMARY PLAN DESCRIPTION AND
PLAN DOCUMENT OF THE
OHIO CONFERENCE OF PLASTERERS' & CEMENT MASONS'
HEALTH & WELFARE PLAN

WHEREAS, effective as of May 1, 2020, the Plan document of the Ohio Conference of Plasterers' & Cement Masons' Health & Welfare Plan (hereinafter, the "Plan") was amended and restated; and

WHEREAS, the right to further amend the Plan has been reserved to the Board of Trustees of the Plan and the Board of Trustees now desires to exercise such right; and

WHEREAS, the Board of Trustees have elected to amend the Plan to cover (1) emergency services provided at out-of-network facilities and (2) services rendered by out-of-network providers at in-network facilities at the in-network rate in accordance with the No Surprises Act; and

WHEREAS, the Trustees have elected to amend the Plan to cover over-the-counter COVID-19 test in accordance with Federal guidelines issued by the Departments of the Treasury, Labor, and Health and Human Services; and

WHEREAS, the Trustees have elected to amend the Plan to add a ninety (90) day retail supply option for prescription drugs; and

NOW THEREFORE, the Board of Trustees hereby amends the Plan, with said changes having the effective dates set forth below:

1. Effective January 1, 2022, the Plan is hereby amended by removing the description of "Physician's Office" included in the "Schedule of Benefits for Eligible Class I Active Participants and Dependents" and replacing it with the new description for "Physician's Office" as follows:

BENEFIT %						
Physician's Office						
BENEFITS	**HIGH PLAN**		**MID PLAN**		**LOW PLAN**	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Visits for Illness/Injury (online or telehealth visit). Includes both Anthem LiveHealth and Non-LiveHealth Visits	100% after $20 Copay	60% of Allowed Amount**	80% of Allowed Amount	60% of Allowed Amount	70% after $20 Copay	50% of Allowed Amount
Allergy Testing/Treatment	80%*	60% of Allowed Amount**	80%*	60% of Allowed Amount**	70%*	50% of Allowed Amount**

Occupational/Physical/ Speech/Respiratory	80%*	60% of Allowed Amount**	80%*	60% of Allowed Amount**	70%*	50% of Allowed Amount**
Diagnostic Lab/X-Ray	80%*	60% of Allowed Amount**	80%*	60% of Allowed Amount**	70%*	50% of Allowed Amount**
Surgery (All Related Expenses)	80%*	60% of Allowed Amount**	80%*	60% of Allowed Amount**	70%*	50% of Allowed Amount**
COVID-19 Testing	Tests order by a Physician or other medical professional are covered at 100%. For coverage of over-the-counter COVID-19 tests, please see description of coverage for OTC COVID-19 Tests below.					

2. Effective January 15, 2022, the description of "Other Services," in the "Scheduled of Benefits for Eligible Class I Active Participants and Dependents," is hereby amended by removing that description in its entirety and replacing it with the new description for "Other Services" as set forth below:

BENEFITS	HIGH PLAN		MID PLAN		LOW PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
OTHER SERVICES* **						
Skilled Nursing facility	80%*	60% of Allowed Amount**	80%*	60% of Allowed Amount**	70%*	50% of Allowed Amount**
Private Duty Nursing	80%*	60% of Allowed Amount**	80%*	60% of Allowed Amount**	70%*	50% of Allowed Amount**
Home Health Care (40 visits per calendar year)	80%*	60% of Allowed Amount**	80%*	60% of Allowed Amount**	70%*	50% of Allowed Amount**
Hospice Care	80%*	60% of Allowed Amount**	80%*	60% of Allowed Amount**	70%*	50% of Allowed Amount**
Durable Medical Equipment	80%*	60% of Allowed Amount**	80%*	60% of Allowed Amount**	70%*	50% of Allowed Amount**
Ambulance	80%*	60% of Allowed Amount**	80%*	60% of Allowed Amount**	70%*	50% of Allowed Amount**
OTC COVID-19 Tests	Effective January 15, 2022 and until the end of the COVID-19 public health emergency, the Plan will reimburse the cost of Over-the-Counter ("OTC") COVID-19 Tests. See the description for Coverage of OTC COVID-19 Tests below (set forth under the Section entitled "Basic Benefits") for limits and restrictions on the Plan's coverage of OTC COVID-19 Tests.					

*After satisfaction of In-Network Deductible

** After satisfaction of Out-of-Network Deductible

*** For Covered Services rendered by Out-of-Network providers at In-Network facilities on or after May 1, 2022, please see the description for "Services from Out-of-Network Providers at In-Network Facilities" set forth below in the Section entitled "Basic Benefits."

3. Effective March 1, 2022, the Plan is hereby amended by deleting the description of "Prescription Benefits" in the "Scheduled of Benefits for Eligible Class I Active Participants and Dependents," and replacing it with the new description for "Prescription Benefits" as set forth below:

Prescription Benefits			
Retail (34 & 90 Day Supply)	80%	80%	70%
Mail Order (90 Day Supply)			

4. Effective January 15, 2022, the Plan is hereby amended by deleting the description of "Other Services" from the "Schedule of Benefits for Eligible Class II, Class III, and Early Retirees and Dependents," in its entirety and replacing it with the new description for "Other Services," as follows:

BENEFITS		
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Other Services* **		
Skilled Nursing Facility	80%*	60% Allowed Amount**
Private Duty Nursing	80%*	60% Allowed Amount**
Home Health Care (40 visits per calendar year)	80%*	60% Allowed Amount**
Hospice Care	80%*	60% Allowed Amount**
Durable Medical Equipment	80%*	60% Allowed Amount**
Ambulance	80%*	60% Allowed Amount**
COVID-19 Testing	Tests order by a Physician or other medical professional are covered at 100%. For coverage for over-the-counter COVID-19 tests, please see description of coverage for OTC COVID-19 Tests below.	

*After satisfaction of In-Network Deductible
** After satisfaction of Out-of-Network Deductible
*** For Covered Services rendered by Out-of-Network providers at In-Network facilities on or after May 1, 2022, please see the description for "Services from Out-of-Network Providers at In-Network Facilities" set forth below in the Section entitled "Basic Benefits."

5. Effective March 1, 2022, the Plan is hereby amended by deleting the description of "Prescription Benefits" in the "Schedule of Benefits for Eligible Class II, Class III, and Early Retirees and Dependents," and replacing it with the new description for "Prescription Benefits" as set forth below:

Prescription Benefits	
Retail (34 & 90 Day Supply)	80%
Mail Order (90 Day Supply)	80%

6. Effective May 1, 2022, the Plan is hereby amended by deleting the description of "Ambulance Services" under the Section entitled, "Basic Benefits," and replacing that with the new description of "Ambulance Services" as set forth below:

AMBULANCE SERVICES

Medically Necessary Ambulance Services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, You are taken:
  - From Your home, the scene of an accident or Medical Emergency to a Hospital.
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network hospital.
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, You are taken:
  - From the scene of an accident or Medical Emergency to a Hospital.
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital.
  - Between a Hospital and an approved Facility.

Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider. Effective May 1, 2022, all Emergency air ambulance services will be covered at the In-Network rate regardless of whether the Provider is Out-of-Network.

Non-Emergency Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, for non-Emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If You do not use the air ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill You for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases, the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility. Benefits also include Medically Necessary treatment of a sickness or Injury by medical professionals from an ambulance

service, even if You are not taken to a Facility. Ambulance Services are not covered when another type of transportation can be used without endangering Your health. Ambulance Services for Your convenience or the convenience of Your family or Physician are not a Covered Service.

Other non-covered Ambulance Services include, but are not limited to:

- a Physician's office or clinic; or
- a morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger Your health and Your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if You are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if You are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation Facility), or if You are taken to a Physician's office or Your home.

Hospital to Hospital Transport

If You are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger Your health and if the Hospital that first treats cannot give You the medical services You need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You. **Coverage is not available for air ambulance transfers simply because You, Your family, or Your Provider prefers a specific Hospital or Physician.**

7. Effective January 15, 2022, the Plan is hereby amended by adding the following description for "Coverage of Over-the-Counter COVID-19 Tests" to the end of the existing provisions in the Section entitled, "Basic Benefits," as follows:

COVERAGE OF OVER-THE-COUNTER COVID-19 TESTS

Effective January 15, 2022 and until the end of the public health emergency for COVID-19, the Plan will cover over-the-counter (OTC) COVID-19 Tests approved by the U.S. Food and Drug Administration which are self-administered and self-read. The Plan will cover up to eight (8) tests per Covered Person each thirty (30) day period. Participants must purchase the test out-of-pocket and submit proper documentation evidencing the purchase to the Plan or Pharmacy Benefit Manager for reimbursement, as determined by the Board. COVID-19 Tests can be obtained without a physician's note or order but must be for diagnostic purposes only. Any

OTC COVID-19 Test that is used for employment, school, or recreational purposes is not eligible for reimbursement under the Plan.

8. Effective May 1, 2022, the Plan is hereby amended by adding the following description for "Services from Out-of-Network Providers at In-Network Facilities" to the end of the existing provisions in the Section entitled, "Basic Benefits" as follows:

SERVICES FROM OUT-OF-NETWORK PROVIDERS AT IN-NETWORK FACILITIES

Effective May 1, 2022, if a Covered Person receives care from an out-of-network provider at an in-network facility, then the Covered Person will be responsible for any cost sharing (including any copayment, coinsurance, deductible, or other out-of-pocket expense requirement) as it relates to the out-of-network provider as if the out-of-network provider were an in-network provider and under the same terms as for in-network care. Covered Persons receiving such treatment shall also not be balance billed even though the provider is out-of-network. Examples of common out-of-network charges rendered at in-network facilities include, but are not limited to, Emergency Room Doctors, Anesthesiologists, Pathologists, and Radiologists. Notwithstanding the foregoing, if the provider obtains consent of the Covered Person to charge the out-of-network rate, and such consent meets all conditions set forth in 42 U.S.C. §300gg-132(d) and its associated provisions, then such treatment may be covered at the out-of-network rate and subject to balance billing.

9. Effective May 1, 2022, the Plan is hereby amended by removing the definition of "Emergency Medical Condition" in its entirety and replacing it with the new definition for Emergency Medical Condition" as follows:

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions, that there is inadequate time to affect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

10. Effective May 1, 2022, the Plan is hereby amended by removing the definition of "Emergency Services" and replacing it with the "Emergency Services" as follows:

Emergency Services – a medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital or of an

Independent Freestanding Emergency department, including ancillary services routinely available to the emergency department of a Hospital or Independent Freestanding Emergency department to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or Independent Freestanding Emergency department, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient.

IN WITNESS WHEREOF, this Third Amendment has been executed this 8th day of April 2022 but is effective on the dates set forth above.

BOARD OF TRUSTEES OF THE
OHIO CONFERENCE OF PLASTERERS' & CEMENT MASONS'
HEALTH & WELFARE PLAN

On Behalf of Employer Trustees:

Kevin Reilly, Secretary/Treasurer

On Behalf of Union Trustees:

Charles Wanat, Chairman